

- (a) ADJUSTMENTS MAY BE MADE TO THE COST REPORT AS NECESSARY TO DETERMINE REASONABLE AND ACCURATE INTERIM PAYMENT RATES.
- (b) ADJUSTMENTS MADE BY ODHS DO NOT PRECLUDE FINDINGS OF ADDITIONAL COST EXCEPTIONS ISSUED AS THE RESULT OF FIELD AUDIT OR FINAL SETTLEMENT.
- (c) FOR THE PURPOSE OF UPDATING INTERIM PAYMENT RATES, ALL OF WHICH ARE SUBJECT TO COST SETTLEMENT, DESK AUDIT PROCEDURES WILL TAKE INTO CONSIDERATION THE RELATIONSHIP BETWEEN THE PRIOR YEAR'S AUDITED COSTS AND THE CURRENT YEAR'S REPORTED COSTS.
- (d) UPPER LIMITS OR RATE OF INCREASE LIMITATIONS AS ESTABLISHED BY ODHS SHALL BE USED IN DETERMINING INTERIM PAYMENT RATES.

(F) REIMBURSEMENT:

- (1) THE MEDICAID REIMBURSEMENT TO CERTIFIED HABILITATION CENTERS WHICH PARTICIPATE AS PROVIDERS IN THE ICF-MR COMPONENT OF THE MEDICAID-COVERED HABILITATION CENTER PROGRAM, FOR THE DELIVERY OF ACTIVE TREATMENT SERVICES (AS DEFINED IN RULE 5101:3-37-13 OF THE ADMINISTRATIVE CODE), IS MADE ON A COST-SETTLED PER-DIEM-PER-RECIPIENT BASIS. THIS PER DIEM WILL INCLUDE REIMBURSEMENT FOR ANY SERVICES WHICH MUST BE DELIVERED BY LICENSED PROFESSIONALS THAT ARE A PART OF THE RECIPIENT'S ACTIVE TREATMENT PROGRAM AND ARE DELIVERED UNDER THE ICF-MR COMPONENT OF THE PROGRAM.
 - (a) IN ORDER TO FACILITATE THE PAYMENT PROCESS, PROVIDERS SHALL UTILIZE THE ODHS MEDICAID CLAIM BILLING SYSTEM FOR THE FILING OF RECIPIENT SPECIFIC CLAIMS FOR ACTIVE TREATMENT SERVICES. A MAXIMUM OF ONE UNIT OF ACTIVE TREATMENT SERVICES MAY BE CLAIMED FOR ANY GIVEN RECIPIENT ON ANY GIVEN DAY, REGARDLESS OF THE DURATION AND/OR SCOPE OF THE SERVICES (INCLUDING SERVICES WHICH MUST BE DELIVERED BY A LICENSED PROFESSIONAL THAT ARE A PART OF THE RECIPIENT'S ACTIVE TREATMENT PROGRAM) PROVIDED TO THE RECIPIENT ON THAT DAY. THE MAXIMUM NUMBER OF REIMBURSABLE UNITS OF ACTIVE TREATMENT SERVICES SHALL BE EQUAL TO THE NUMBER OF DAYS ON WHICH THE RECIPIENT RECEIVED SUCH SERVICES DURING THE BILLING PERIOD FOR WHICH A CLAIM WAS FILED.
 - (b) INTERIM MEDICAID PAYMENTS SHALL BE MADE FOR ACTIVE TREATMENT SERVICE CLAIMS THAT ARE FILED IN ACCORDANCE WITH

89-20 Date Rec'd 9-5-89
Date New Date App'd 10-18-90
Date 7/1/89

PARAGRAPH (F)(1)(a) OF THIS RULE. THE MAXIMUM REIMBURSABLE AMOUNT FOR SUCH INTERIM PAYMENTS SHALL BE EQUAL TO THE STANDARD PER DIEM RATE WHICH WAS IN EFFECT AT THE TIME THE SERVICE WAS DELIVERED, TIMES THE NUMBER OF DAYS THE RECIPIENT ACTUALLY RECEIVED ACTIVE TREATMENT SERVICES DURING THE BILLING PERIOD FOR WHICH THE CLAIM WAS MADE. BILLING PERIODS AND/OR CLAIMS SHALL NOT STRADDLE RATE YEARS.

- (c) FOR FISCAL YEAR 1990, THE STANDARD PER DIEM RATE SHALL BE TWENTY DOLLARS (APPROXIMATELY EIGHT FIVE PER CENT OF THE CALENDAR YEAR 1988 AVERAGE HABILITATION CENTER COSTS PER DAY).

FOR FISCAL YEAR 1991, THE FISCAL YEAR 1990 TWENTY DOLLAR PER DIEM RATE WILL BE ADJUSTED FOR INFLATION BY THE MOST RECENT "SERVICES LESS RENT OF SHELTER" INDEX FROM THE TABLE "ALL URBAN CONSUMERS: SEASONALLY ADJUSTED" FOUND IN THE "CONSUMER PRICE INDEX" PUBLISHED BY THE UNITED STATES DEPARTMENT OF LABOR.

FOR EACH RATE YEAR THEREAFTER, PROVIDER SPECIFIC PER DIEM RATES WILL BE CALCULATED BY ODHS BASED ON EACH SPECIFIC PROVIDER'S REASONABLE AND ALLOWABLE COSTS PER RECIPIENT DAY AS REPORTED FOR THE LAST COST REPORTING PERIOD PRIOR TO THE RATE YEAR.

BOTH THE STANDARD AND THE PROVIDER SPECIFIC PER DIEM RATES ARE SUBJECT TO AUDIT AND ADJUSTMENT AT FINAL SETTLEMENT.

- (2) THE MEDICAID REIMBURSEMENT TO CERTIFIED HABILITATION CENTERS WHICH PARTICIPATE IN THE COMMUNITY-BASED COMPONENT OF THE MEDICAID-COVERED HABILITATION CENTER PROGRAM, IS MADE ON A FEE-FOR-SERVICE PAID FOR UNITS OF SERVICE RENDERED BASIS. CLAIMS FOR SERVICES RENDERED UNDER THIS COMMUNITY-BASED COMPONENT SHALL UTILIZE THE ODHS MEDICAID CLAIM BILLING SYSTEM.

- (a) FOR FISCAL YEARS 1990 AND 1991 THE MAXIMUM REIMBURSABLE AMOUNT FOR A UNIT OF PROFESSIONAL SERVICES OTHER THAN PHYSICIAN, NURSING AND DELEGATED NURSING SERVICES (AS DEFINED IN RULE 5101:3-37-16 OF THE ADMINISTRATIVE CODE), SHALL BE BASED UPON THE HOURLY WAGE COMPONENTS UTILIZED FOR LONG-TERM CARE FACILITIES FOR THE CORRESPONDING FISCAL YEAR. THESE WAGE COMPONENTS SHALL BE DETERMINED ACCORDING TO RULE 5101:3-3-192 OF THE ADMINISTRATIVE CODE AND WILL BE CALCULATED ANNUALLY AS PART OF THE LONG-TERM CARE FACILITY

89-20
NEW
7/1/89

INTERIM SETTLEMENT PROCESS. THE MAXIMUM REIMBURSABLE AMOUNT FOR A UNIT OF PROFESSIONAL SERVICES OTHER THAN PHYSICIAN, NURSING AND DELEGATED NURSING SERVICES SHALL BE EQUAL TO FORTY PER CENT OF THE APPROPRIATE HOURLY WAGE COMPONENT.

THE MAXIMUM REIMBURSABLE AMOUNT FOR A UNIT OF NURSING SERVICES SHALL BE EQUAL TO FORTY PER CENT OF THE STATEWIDE AVERAGE HOURLY WAGE COMPONENTS FOR REGISTERED NURSES AND LICENSED PRACTICAL NURSES.

THE MAXIMUM REIMBURSABLE AMOUNT FOR A UNIT OF DELEGATED NURSING SERVICES SHALL BE EQUAL TO FORTY PER CENT OF THE STATEWIDE AVERAGE HOURLY WAGE COMPONENT FOR NURSING AIDES AND ORDERLIES.

THE MAXIMUM REIMBURSABLE AMOUNT FOR A UNIT OF PHYSICIAN SERVICES SHALL BE THE ALLOWABLE MEDICAID RATE FOR AN OFFICE VISIT (INTERMEDIATE SERVICE TO AN ESTABLISHED PATIENT), AS SPECIFIED IN APPENDIX DD OF RULE 5101:3-1-60 OF THE ADMINISTRATIVE CODE.

THESE MAXIMUM REIMBURSABLE AMOUNTS ARE ESTABLISHED AT A RATE TO INCLUDE THE COST OF ADMINISTRATIVE ACTIVITIES SUCH AS PLANNING, RECORD KEEPING, INTERDISCIPLINARY TEAM REVIEW, ETC., (AS OUTLINED IN RULE 5101:3-37-16 OF THE ADMINISTRATIVE CODE). TIME SPENT PERFORMING SUCH ACTIVITIES IS NOT BILLABLE.

- (b) FOR ALL SUBSEQUENT RATE YEARS, PROVIDER SPECIFIC RATES FOR ALL PROFESSIONAL SERVICES WILL BE CALCULATED BASED ON REASONABLE AND ALLOWABLE COSTS AND DELIVERY OF SERVICE DATA AS REPORTED FOR THE LAST COST REPORTING PERIOD BEFORE THE RATE YEAR.

THESE PROVIDER SPECIFIC RATES WILL BE ESTABLISHED TO INCLUDE THE COST OF ADMINISTRATIVE ACTIVITIES SUCH AS PLANNING, RECORD KEEPING, INTERDISCIPLINARY TEAM REVIEW, ETC. (AS OUTLINED IN RULE 5101:3-37-16 OF THE ADMINISTRATIVE CODE). TIME SPENT PERFORMING SUCH ACTIVITIES IS NOT BILLABLE.

- (c) ALL FISCAL YEAR PROFESSIONAL SERVICE RATES ARE SUBJECT TO AUDIT AND FINAL COST SETTLEMENT.

- (3) TRANSPORTATION SERVICES DELIVERED AS A PART OF THE MEDICAID-COVERED HABILITATION CENTER PROGRAM WILL BE REIMBURSED ON A PER UNIT OF TRANSPORTATION SERVICE BASIS FOR BOTH THE ICP-MR AND COMMUNITY-BASED COMPONENTS OF THE PROGRAM.

89-20
NEW

9-5-89
10-18-90
7/1/89

- (a) FOR FISCAL YEARS 1990 AND 1991, THE STATEWIDE TRANSPORTATION PAYMENT RATE SHALL BE TWO DOLLARS AND FIFTY CENTS PER UNIT OF TRANSPORTATION SERVICE. THIS IS APPROXIMATELY NINETY PER CENT OF THE ODMR/DD STATEWIDE PER-TRIP COST (ONE WAY), FOR CALENDAR YEAR 1988.
 - (b) FOR ALL SUBSEQUENT FISCAL YEARS, THE TRANSPORTATION RATE WILL BE CALCULATED BASED ON PROVIDER SPECIFIC REASONABLE AND ALLOWABLE TRANSPORTATION COSTS AND DELIVERY OF SERVICE DATA AS REPORTED FOR THE LAST COST REPORTING PERIOD PRIOR TO THE RATE YEAR.
 - (c) ALL FISCAL YEAR TRANSPORTATION RATES ARE SUBJECT TO AUDIT AND FINAL COST SETTLEMENT.
- (4) BEGINNING IN FISCAL YEAR 1992, ANY NEW PROVIDER ENROLLED IN THE MEDICAID-COVERED HABILITATION CENTER PROGRAM (IN ACCORDANCE WITH REQUIREMENTS IN RULE 5101:3-37-01 OF THE ADMINISTRATIVE CODE), THAT HAS NOT SUBMITTED A COST REPORT FOR THE PRIOR COST REPORTING PERIOD, SHALL BE REIMBURSED ON AN INTERIM BASIS AT SEVENTY FIVE PER CENT OF THE AVERAGE STATEWIDE HABILITATION CENTER RATES FOR ACTIVE TREATMENT, PROFESSIONAL SERVICES AND TRANSPORTATION, UNTIL SUCH TIME AS THE PROVIDER HAS FILED A COST REPORT FOR ONE FULL COST REPORTING PERIOD.
- (a) UPON WRITTEN APPROVAL BY ODHS, THE PROVIDER MAY SUBMIT A COST REPORT AFTER SIX CONSECUTIVE MONTHS OF EXPERIENCE.
 - (b) SUBSEQUENT RATES SHALL BE CALCULATED IN ACCORDANCE WITH THE PREVIOUSLY DESCRIBED PROVISIONS OF THIS RULE.
 - (c) THESE RATES ARE SUBJECT TO AUDIT AND FINAL COST SETTLEMENT.
- (G) AUDITS:
- (1) PROGRAM AUDITS SHALL BE CONDUCTED FOR THE PURPOSE OF DETERMINING WHETHER SERVICES WERE PROVIDED AND CLAIMED IN ACCORDANCE WITH THE RULES CONTAINED IN CHAPTER 5101:3-37 OF THE ADMINISTRATIVE CODE. PROGRAM AUDITS SHALL BE CONDUCTED AT THE SERVICE DELIVERY SITES OF THE PARTICIPATING PROVIDERS WITHIN FOUR MONTHS OF THE CLOSE OF THE PROVIDER'S FISCAL REPORTING PERIOD (UNLESS FORMAL NOTICE IS GIVEN THE PROVIDER BY THE DEPARTMENT RESPONSIBLE FOR CONDUCTING THE PROGRAM AUDIT), AND EVERY THREE YEARS THEREAFTER, OR AS DEEMED NECESSARY BY THE DEPARTMENT RESPONSIBLE FOR THE PROGRAM AUDIT. PROGRAM AUDITORS SHALL REVIEW RECIPIENT CHARTS/RECORDS

89-20

New

7/1/89

AND ANY REQUIRED CONTRACTS; SHALL INTERVIEW/OBSERVE RECIPIENTS; AND SHALL RECONCILE PROGRAM DOCUMENTATION WITH THE CLAIMS SUBMITTED FOR THAT YEAR. PROGRAM AUDIT RESULTS SHALL BE REPORTED TO THE PROVIDER AND ODHS.

- (2) FISCAL AUDITS SHALL BE CONDUCTED FOR THE PURPOSE OF ENSURING THAT ALL APPLICABLE MEDICAID REIMBURSEMENT STANDARDS HAVE BEEN MET, AND THAT ANY NECESSARY ADJUSTMENTS ARE MADE TO MEDICAID PAYMENTS FOR A FINAL SETTLEMENT OF CLAIMS FOR THE COST REPORTING PERIOD. THE EXAMINATION OF HABILITATION COSTS AND CHARGES WILL BE MADE IN ACCORDANCE WITH TITLE XVIII PRINCIPLES OF REASONABLE COST REIMBURSEMENT AND ~~GENERALLY~~ ACCEPTED AUDITING STANDARDS AS NECESSARY TO FULFILL THE SCOPE OF THE AUDIT. FISCAL AUDITS WILL GENERALLY BE CONDUCTED WITHIN ONE YEAR OF THE CLOSE OF THE PROVIDER'S FISCAL REPORTING PERIOD OR THE DATE THAT ALL PROVIDER BILLINGS FOR THE REPORTING PERIOD HAVE BEEN PROCESSED, WHICHEVER IS LATER. ALL FISCAL AUDITS WILL INCORPORATE THE RESULTS OF THE MOST RECENT PROGRAM AUDIT.

TO FACILITATE THIS EXAMINATION, PROVIDERS ARE REQUIRED TO MAKE AVAILABLE ALL RECORDS NECESSARY TO FULLY DISCLOSE THE EXTENT OF SERVICES PROVIDED TO ALL PATIENTS, THE CORRESPONDING COSTS AND CHARGES MADE AND PAYMENTS RECEIVED FOR SUCH SERVICES, AND THE PROVIDER'S AUDITED FINANCIAL STATEMENT FOR THE PERIOD CORRESPONDING TO THE COST-REPORTING PERIOD. BASED ON THE AUDIT, ADJUSTMENTS IN PAYMENTS TO THE PROVIDER WILL BE MADE AS REQUIRED BY PROVISIONS OF THIS AND ANY OTHER APPLICABLE RULE. RECORDS NECESSARY TO FULLY DISCLOSE THE EXTENT OF SERVICES PROVIDED MUST BE MAINTAINED FOR A PERIOD OF SEVEN YEARS FROM THE DATE OF RECEIPT OF PAYMENT OR FOR SIX YEARS AFTER ANY INITIATED AUDIT IS COMPLETED AND ADJUDICATED, WHICHEVER IS LONGER. SAID RECORDS MUST BE MADE AVAILABLE, UPON REQUEST, TO ODHS OR OTHERS DESIGNATED BY ODHS FOR AUDIT PURPOSES. NO PAYMENT FOR OUTSTANDING HABILITATION CLAIMS CAN BE MADE IF A REQUEST FOR AUDIT IS REFUSED.

- (3) ALL AUDIT ACTIVITIES DESCRIBED IN THIS RULE MAY BE UNDERTAKEN DURING ANY RATE YEAR FOR THE PURPOSE OF ENSURING ACCURACY OF DATA MAINTAINED BY THE DEPARTMENT FOR RATE-SETTING OR ANALYSIS PURPOSES. AUDITS ARE PERFORMED TO VERIFY THAT TOTAL PROGRAM REIMBURSEMENT IS LESS THAN OR EQUAL TO PROGRAM COST. AUDITS WILL ALSO DETERMINE WHETHER:

(a) SERVICES BILLED WERE PROVIDED;

89-20
New

9-5-89
10-18-90
7/1/89

- (b) SERVICES BILLED TO THE PROGRAM WERE PROVIDED TO PERSONS ELIGIBLE AS MEDICAID RECIPIENTS ON THE DATE(S) SERVICES WERE RENDERED;
- (c) SERVICES BILLED ARE COVERED UNDER THE MEDICAID PROGRAM IN ACCORDANCE WITH RULES 5101:3-37-01 TO 5101:3-37-22 OF THE ADMINISTRATIVE CODE;
- (d) COSTS REPORTED TO THE DEPARTMENT REPRESENT ACTUAL INCURRED, REASONABLE, AND ALLOWABLE COSTS IN ACCORDANCE WITH THE PROVISIONS OF THIS RULE;
- (e) THIRD PARTY PAYORS ARE BILLED, AND AMOUNTS OF THIRD-PARTY PAYMENTS REPORTED TO THE DEPARTMENT REFLECT THE ACTUAL AMOUNTS RECEIVED;
- (f) ANY MEDICAID PROGRAM DAYS AND PROFESSIONAL SERVICE UNITS REPORTED ON THE COST REPORT ARE CONSISTENT WITH THOSE REFLECTED FOR THE SAME PERIOD IN THE ODHS PAID CLAIMS HISTORY. IN CASES WHERE DATA SUBMITTED BY THE HABILITATION CENTER ON THE COST REPORT ARE INCONSISTENT WITH DATA IN THE ODHS PAID CLAIM DATA FILE, THE COST REPORT MAY BE ADJUSTED;
- (g) REASONABLE AND ALLOWABLE COSTS ARE OFFSET BY ALL FEDERAL GRANTS; AND
- (h) LOCAL MATCHING FUNDS ARE MADE AVAILABLE AND ACCOUNTED FOR PROPERLY.

(H) FINAL SETTLEMENTS:

- (1) FOLLOWING THE COMPLETION OF THE AUDIT PROCESS, THE BUREAU OF HOSPITAL RATES AND AUDITS SHALL DETERMINE WHETHER ANY ADJUSTMENTS TO THE MEDICAID PAYMENT ARE REQUIRED TO ACHIEVE A FINAL SETTLEMENT FOR THAT REPORTING PERIOD. THE BUREAU OF HOSPITAL RATES AND AUDITS SHALL PREPARE A FINAL SETTLEMENT REPORT FOR EACH PROVIDER. A COPY OF THE REPORT WILL BE FORWARDED TO THE MEDICAID-COVERED HABILITATION CENTER PROGRAM AND ODHS.
- (2) UNDERPAYMENTS AND OVERPAYMENTS DETERMINED AS A RESULT OF THE AUDIT PROCESS WILL BE RECONCILED AT THE TIME OF FINAL SETTLEMENT.
 - (a) WHEN IT HAS BEEN DETERMINED THAT AN OVERPAYMENT HAS BEEN MADE TO A GIVEN PROVIDER, THAT PROVIDER MUST MAKE RESTITUTION OF THE FEDERAL SHARE OF THE AMOUNT OF THE OVERPAYMENT.

89-10 Date Rec'd _____
New Date Appr. _____
Date Eff. 7/4/89

- (b) WHEN IT HAS BEEN DETERMINED THAT AN UNDERPAYMENT HAS BEEN MADE TO A GIVEN PROVIDER, ODHS WILL REIMBURSE THAT PROVIDER IN AN AMOUNT EQUAL TO THE FEDERAL SHARE OF THE UNDERPAYMENT.

- (3) A PROVIDER MAY APPEAL IMPOSITION OF A FINAL SETTLEMENT PURSUANT TO CHAPTER 119. OF THE REVISED CODE AND CHAPTER 5101:3-5 OF THE ADMINISTRATIVE CODE.

EFFECTIVE: _____

CERTIFICATION _____

DATE _____

PROMULGATED UNDER: REVISED CODE
SECTION 119.03

RULE AMPLIFIES: REVISED CODE
SECTIONS 5111.02 AND 5111.041

1179 # 89-12 Date Rec'd 9-5-89
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7/1/89